SUPREME COURT, U.S.
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No. 00-1471

In The
Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, *et al.*,

Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF FOR THE SOCIETY FOR HUMAN RESOURCE MANAGEMENT AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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INTEREST OF AMICUS CURIAE[1]

The Society for Human Resource Management (SHRM) is the world's largest association devoted to human resource (HR) management. Founded in 1948, SHRM has more than 500 affiliated chapters within the United States and members in more than 120 countries. SHRM represents more than 170,000 individual members, ranging from HR managers to top HR executives. Its membership encompasses every industry and ranges from one-person consulting firms to Fortune 500 companies. SHRM is committed to advancing the HR profession and making HR an essential and effective partner in organizational strategy. It serves the needs of HR professionals by providing them with essential resources to perform their functions in every HR discipline, including benefits administration, employee relations and staffing.

SHRM prides itself on being an association of professionals concerned with the needs and interests of American workers. Its views are very close to those of the employees served by SHRM members. Thus, health care coverage and administration are matters of significant concern among SHRM's members, many of whom deal with benefits-related issues on a daily basis.

SHRM supports the orderly development of the law of employee benefits. SHRM encourages the voluntary adoption of employee benefit plans regulated by the

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[1] All parties in this case have submitted letters of consent for this brief to be filed, in accordance with S. Ct. Rule 37.3(a). Counsel for a party did not author this brief in whole or in part. No persons or entities other than the *Amicus Curiae*, its members or its counsel made a monetary contribution to the preparation or submission of this brief.

Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq*. One of the most attractive features of ERISA is the freedom it affords employee health benefit programs – especially those which are self-insured – by exempting them from state regulation. Preemption creates a strong incentive for employers to establish, customize and maintain employee health benefit plans. This incentive is particularly meaningful to employers that operate in multiple states. Many SHRM members are employed by employers that operate in a multi-state environment.

SHRM views ERISA preemption as a means of maintaining and improving health care now provided to American workers.

THE DECISION OF THE COURT OF APPEALS

This case addresses whether ERISA preempts Kentucky's "any willing provider" ("AWP") statute, which requires a health "insurer" to admit into its managed care network "any provider who is located within the geographical coverage of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer[.]" KY. REV. STAT. § 304.17A-270. The statute's definition of "insurer" is not a limited one, but rather expressly encompasses all that ERISA does not:

> any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement *not exempt from state regulation by ERISA*; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

KY. REV. STAT. § 304.17A-005(23) (emphasis added).

In a 2-1 opinion, the Court of Appeals for the Sixth Circuit held that the statute "relates to" employee benefit plans governed by ERISA, *see Kentucky Assoc. of Health Plans, Inc., et al. v. Nichols*, 227 F.3d 352, 358-63 (6th Cir. 2000); 29 U.S.C. § 1144(a), but is saved from preemption because it is a law regulating the business of insurance, 227 F.3d at 363-72; 29 U.S.C. § 1144(b)(2)(A). The dissent agreed that the statute "relates to" ERISA plans, but reasoned that Kentucky's AWP statute does not regulate the business of insurance. *Id.* at 372-83.

SUMMARY OF ARGUMENT

ERISA health benefit plans account for the majority of American health coverage. Health costs are a dramatically increasing component of total employee compensation. Managed care networks (MCNs), utilized by many ERISA plans to provide cost-effective health coverage, are a grouping of medical providers who meet specific quality standards and receive a guaranteed volume of business from plan participants, in return for which the medical providers agree to fee discounts. ERISA plans use MCNs to provide quality health care at relatively low rates, and they are under attack by AWP statutes.

Any Willing Provider statutes like Kentucky's will undercut the cost-containment options available to ERISA health plans at a time when more, not less, cost control is

sorely needed. If MCNs are forced to accept more health care providers into their networks, they will lose bargaining power to control costs because the guaranteed volume per provider will decrease. The providers will negotiate higher fees to account for the reduced volume, and premiums for coverage will increase to pay these increased fees. The more expensive it is for employers to offer health benefits, the more likely they are to reduce benefits, or transfer money from benefits to the wage component of total employee compensation, in order to fix costs. Either way, most employees will become less insured, less healthy and less productive. ERISA preemption should be read to preclude state AWP laws and their associated costs to employees.

The ERISA preemption analysis should begin and end "by simply asking if state law conflicts with the provisions of ERISA or operates to frustrate its objects." *Boggs v. Boggs*, 520 U.S. 833, 841 (1997). The Congressional policy embodied in ERISA preempts Kentucky's AWP law because ERISA generally establishes and safeguards employer freedom to define the terms of ERISA plans and customize benefit plan design (especially self-insured plans) – without state intervention. The Kentucky AWP law contradicts this fundamental ERISA principle by limiting the availability of MCNs as health care delivery vehicles for ERISA plans. Kentucky's law also runs contrary to ERISA's policy of minimizing the administrative burden on employers – multi-state employers in particular – who sponsor health benefit plans. Upholding AWP laws like Kentucky's will force employers to structure and administer their plans on a state-by-state basis, which is "exactly the burden ERISA seeks to eliminate." *Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001).

Kentucky's law does not regulate the business of insurance and is not therefore saved from preemption. The law fails to satisfy the common sense meaning of the business of insurance. The statute is *not* limited to entities within the insurance industry; rather, it purports to regulate all arrangements "not exempt from state regulation by ERISA." *See* KY. REV. STAT. § 304.17A-005(23).

Comprehensive federal health reform is a work in progress and an active part of the Congressional legislative agenda. At present, however, ERISA remains the last federal consensus on employee health benefit plans, and it represents a policy that gives plans the freedom to confront the health care cost crisis without state intervention. ERISA policy thus encourages employers to provide health benefits to their workers. The worst approach to the health care crisis would be the judicial abandonment of this policy by allowing states to undermine MCNs. The Court should reverse the decision below, hold that Kentucky's AWP statute is preempted by ERISA, and preserve the ability of employers to administer cost-effective ERISA health plans through MCNs, without state intervention.

ARGUMENT

I. ERISA HEALTH PLANS USE MCNs AS THEIR PRINCIPAL METHOD OF COST CONTAINMENT.

Employer-sponsored health plans, which are voluntarily adopted by employers, account for the majority of Americans' health insurance. In 2000, approximately 67 percent of the United States population under age 65 (163.4 million Americans, including 46 million children)

received health care coverage from an employer-sponsored health plan. *See* Paul Fronstin, *Number of Americans with Job-Based Health Benefits Increased in 2000 While Uninsured Declined*, EMPLOYEE BENEFIT RESEARCH INSTITUTE NEWSLETTER, vol. 22, No. 11, November 2001, at 1-2. The percentage of American workers enrolled in employer-sponsored managed care plans, moreover, has increased from 27 percent in 1988 to 93 percent in 2001. KAISER FAMILY FOUNDATION, TRENDS AND INDICATORS IN THE CHANGING MARKETPLACE, MAY 2002 CHARTBOOK 17 (citations omitted), *available at* http://www.kff. org [hereinafter TRENDS AND INDICATORS].

MCNs provide quality health care and control costs by grouping together select medical providers who meet specific standards and receive a guaranteed volume of business from managed care plan participants. In return, the providers agree to discount their fees. MCNs aim to guarantee plan participants access to all necessary health care through a network. To encourage participants to use network providers, participants pay more for non-emergency treatment obtained from a non-network provider.

Employers who self-insure their health plans contract with MCNs to make available the MCN's network of providers. An employer who sponsors a self-insured plan typically pays the employees' health benefit claims out of its general assets as claims are incurred. Under such an arrangement, the employer bears the financial risk associated with its employees' health care expenses. *See* U.S. General Accounting Office, GAO/HEHS-95-167, *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA* at 3 & n.2 (1995). Thus, MCNs represent at

present the key operating delivery vehicle providing health care for American workers.

II. ABSENT ERISA PREEMPTION OF STATE AWP LAWS, ERISA PLANS WILL HAVE FEWER MCNs WITH WHICH TO CONTRACT, AND WILL INCUR HIGHER HEALTH COSTS.

Since the time of the first health care crisis in the early 1990s, employers have experimented with health plan cost control methods in order to continue offering health benefits. Premiums for the traditional "fee for service" indemnity health plans increased 18 percent in 1989 alone. *See* TRENDS AND INDICATORS at 28 (citations omitted), *available at* http://www.kff.org. These increases were due in part to patient demands for, and physician acquiescence to, unnecessary tests or procedures – a practice that went virtually unchecked in indemnity plans.

Managed care then emerged, and to date it remains the best hope to contain health care costs (as evidenced by the fact that 93 percent of employees receiving employer-sponsored health benefits were enrolled in a managed care plan in 2001, *see* TRENDS AND INDICATORS at 17 (citations omitted), *available at* http://www.kff.org). Even so, the cost of health benefits has steadily increased. Overall health insurance expenses increased 8.3 percent between 1999 and 2000, 11 percent between 2000 and 2001, and 12.7 percent between 2001 and 2002. THE KAISER FAMILY FOUNDATION AND HEALTH RESEARCH AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 2002 ANNUAL SURVEY 14 (citations omitted), *available at* http://www.kff.org. For

employer-sponsored plans that offer HMO benefits, initial 2003 HMO rates (pre-negotiation) are increasing at an average of 22 percent. *HMO Rates Continue to Rise at Double Digit Pace*, HEWITT ASSOCIATES PRESS RELEASE, *available at* http://www.hewitt.com.

To combat rising costs, some employers have shifted expenses to their employees by increasing employees' premium contributions, deductibles or co-payments. BNA, Inc., *Rising Health Care Costs Prompt Myriad Initiatives*, BNA HEALTH CARE POLICY REPORT, vol. 10, no. 8 at 303-04 (Feb. 25, 2002); BNA, Inc., *Rising Health Care Costs Prompt Myriad Initiatives*, BNA BULLETIN TO MANAGEMENT, vol. 53, no. 7, Part 2 at S1-S3 (Feb. 14, 2002); *see also Hughes v. 3M Retiree Medical Plan*, 281 F. 3d 786, 791-93 (8th Cir. 2002) (holding employer did not violate ERISA by increasing premiums for retiree medical benefits). Others have cut back health benefits or even eliminated them altogether – particularly for retirees. *See, e.g., Sprague v. General Motors Corp.* 133 F.3d 388, 399-406 (6th Cir. 1998) (*en banc*) (rejecting retirees' claims under ERISA to enforce "lifetime" health benefits after benefits were altered).

If MCNs are forced by the states to accept more health care providers into their networks, they will lose bargaining power in negotiating with providers to join or remain affiliated with a network because the number of guaranteed patients will decrease per provider. The AWP laws certainly will interfere with the ERISA plan's relationship with MCNs. As a result, the networks will become more expensive and less pervasive. *See Recent Legislation*, 109 HARV. L. REV. 2122, 2125 (1996); *see also* TRENDS AND INDICATORS at 55 (setting forth, for each state as of 2000,

number of physicians per 100,000 population) (citations omitted), *available at* http://www.kff.org. Ultimately, the networks may disappear.

AWP-related health plan cost increases will directly affect all ERISA plans, including self-insured plans, that rely on the networks to deliver care to plan participants. Indeed, these laws severely limit – and threaten to eliminate altogether – an entire category of plan design options for employer-sponsored health plans. The end result may be that employers, faced with greater challenges in maintaining an affordable health plan, may choose to reduce the availability of health benefits, completely alter the structure of such benefits, or eliminate them altogether. *See Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 11 (1987) (noting that administrative burdens resulting from no preemption could cause "those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them"). Employers may even lay off employees to compensate for the increased health costs, thus adding to the ranks of the uninsured, underinsured and unemployed. *See* Milt Freudenheim, *Next Big Health Debate: How to Help Uninsured*, N.Y. TIMES, Aug. 27, 2002, at Section C, p.1; Robin Toner and Sheryl Gay Stolberg, *Decade After Health Care Crisis, Soaring Costs Bring New Strains*, N.Y. TIMES, Aug. 11, 2002, at Section 1, p.1 (noting that "Families USA, a consumer advocacy group, has estimated that more than two million Americans lost their insurance last year because of layoffs").

Another possibility is that employers may alter the structure of their benefit plans by allocating a fixed allowance of money per year to cover medical expenses regardless of need. *See generally* I.R.S. Notice 2002-45,

2002-28 I.R.B. 93. Once an employee's health care expenses surpass her allowance, she may become responsible for *all* additional medical expenses. Employees may perceive this structure as a reduction in benefits, which could negatively affect employee morale (and thus reduce productivity) and public perception of the employer (and thus reduce employer profits). *See* Phyllis C. Borzi, *Are Defined Contribution Health Plans the Silver Bullet?* at Part III, *available at* http://www.abanet.org. Such plans may not provide employees with the "best value for their health care dollars without the leverage that an employer-purchaser provides." *Id.* These plans also may leave older or sicker employees, particularly those with chronic illnesses, in a bind because once those employees surpass their employer-provided allowance, they may have difficulty finding coverage in the individual health plan marketplace. *Id.*

Allowing state regulation that undermines MCNs is a step backwards. ERISA preemption questions have "generated an avalanche of litigation in the lower courts." *DeBuono v. NYSA-ILA Medical and Clinical Serv. Fund*, 520 U.S. 806, 808 n.1 (1997) (citation omitted); indeed, this Court has decided eight ERISA preemption cases in the past decade alone.[2] The Court should protect the most

[2] *See Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151 (2002); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999); *California Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.*, 518 U.S. 1053 (1997); *Boggs*, 520 U.S. 833; *DeBuono*, 520 U.S. 806; *New York State Conference of Blue Cross & Blue Shields Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992).

effective and only proven remaining cost savings method – MCNs – until Congress develops a new health care consensus. *Cf. Pegram v. Herdrich*, 530 U.S. 211, 221 (2000) (the legislature is the "preferable forum for comprehensive investigations and judgments of social value, such as optimum treatment levels and health care expenditure") (internal citations omitted).

III. THE DECISION OF THE COURT OF APPEALS FOR THE SIXTH CIRCUIT CONFLICTS WITH THE FEDERAL POLICY EMBODIED IN ERISA.

Congressional policy embodied in ERISA favors preemption of Kentucky's AWP law. Congress established as federal policy in the ERISA welfare benefit plan context that employers must be free to define plan terms, in their sole judgment, on the theory that substantive benefit mandates would discourage the establishment of welfare plans with attractive benefits.[3] The House Ways and Means Committee that approved ERISA offered this explanation of the need in ERISA for a careful balance of employee protection and employer flexibility:

> Generally, it would appear that the wider or more comprehensive the coverage, vesting, and funding, the more desirable it is from the standpoint of national policy. However, since these plans are voluntary on the part of the employer

[3] To compensate for this freedom, Congress provided employees with a cause of action (regardless of the satisfaction of common law contract elements) for breach of the voluntarily chosen plan terms. *See* § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B).

> and both the institution of new pension plans and increases in benefits depend upon employer willingness to establish or expand a plan, it is necessary to take into account additional costs from the standpoint of the employer. If employers respond to vesting and funding rules by decreasing benefits under existing plans or slowing the rate of formation of new plans, little if anything would be gained from the standpoint of securing broader use of employee pensions and related plans. . . .

H.R. REP. No. 93-807, at 15 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4670, 4682.

The manner in which ERISA plans are structured – by MCNs, traditional indemnity arrangements or otherwise – are matters within the sole discretion of the plan sponsor. *See Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) ("Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan.") (citations omitted); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits. Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.") (citations omitted); *Moore v. Reynolds Metals Co. Retirement Program*, 740 F.2d 454, 456 (6th Cir. 1984) ("Neither Congress nor the courts are involved in either the decision to establish a plan or in the decision concerning which benefits a plan should provide").

To preserve this discretion and encourage employers to offer benefit plans voluntarily, ERISA preempts state laws that relate to ERISA plans, such as those which "mandate[ ] employee benefit structures or their administration." *Travelers*, 514 U.S. at 657-58 (summarizing certain state laws held preempted); *accord Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981) (holding that state law was preempted by ERISA because it "eliminates one method for calculating pension benefits . . . that is permitted by federal law"); 29 U.S.C. § 1144(a).

The Court has summarized Congress's underlying purpose for enacting ERISA's broad preemption clause:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursements of benefits.

Fort Halifax, 482 U.S. at 9. Indeed, the legislative history of ERISA characterizes ERISA's preemption clause as "the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans." 120 CONG. REC. 29197 (1974) (statement of Rep. Dent). Congress preserved especially broad freedom for self-insured employers to structure their benefits as they deem appropriate by exempting self-insured plans from state insurance regulation. *See FMC v. Holliday*, 498 U.S. 52, 61 (1990)

("[S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation 'relates to' the plans.").

The ERISA preemption analysis should begin and end "by simply asking if [the] state law conflicts with the provisions of ERISA or operates to frustrate its objects." *Boggs*, 520 U.S. at 841. Preemption applies if the "state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Id.* at 844 (citation and quotation marks omitted).

The Kentucky AWP law contradicts this fundamental ERISA policy by severely limiting the delivery of medical care through MCNs as a method of structuring health benefits. The Kentucky AWP law mandates that MCNs include "any provider . . . who is willing to meet the terms and conditions for participation established by the health insurer." KY. REV. STAT. § 304.17A-270. *Cf. CIGNA Health Plan of La., Inc. v. Ieyoub*, 82 F.3d 642, 648 (5th Cir. 1996) (holding that Louisiana AWP statute "related to" ERISA plans under § 514(a) of ERISA because the statute "den[ied] insurers, employers, and HMOs the right to structure their benefits in a particular matter . . . effectively requiring ERISA plans to purchase benefits of a particular structure").

These state laws also interfere with another fundamental purpose of ERISA: "eliminating the threat of conflicting and inconsistent State and local regulation," 120 CONG. REC. 29197 (1974) (statement of Rep. Dent), and thus minimizing the administrative burden on employers – multi-state employers in particular – who sponsor health benefit plans. Upholding AWP laws like Kentucky's will force employers to learn the ins and outs of different state laws, and structure and administer their

plans on a state-by-state basis. In other words, these laws require "tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction" – which is "exactly the burden ERISA seeks to eliminate." *Egelhoff*, 532 U.S. at 151; *see also id.* at 149-50 ("Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]'on plan administrators – burdens ultimately borne by the beneficiaries.") (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)).[4]

In short, Kentucky's AWP statute "stands as an obstacle to the accomplishment of the full purposes and objectives of Congress" in enacting ERISA, *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) (citation and quotation marks omitted), because it undermines the principal cost control tool of ERISA health plans and imposes significant administrative burdens on employers who sponsor those plans. *See also Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 56 (1987) (the ERISA scheme "would make little sense" if the states can tinker with it).

[4] The majority below opined that Kentucky's AWP statute would not apply to HMOs providing purely administrative services for self-insured ERISA plans because the statute applies "only to health insurers." 227 F.3d at 367 n.14. The statute, however, unquestionably undercuts MCNs acting in *any* capacity, which in turn directly restricts the ability of ERISA self-insured plans to control benefit costs.

IV. GIVEN THE BREADTH OF ERISA PREEMPTION, NONE OF ITS EXCEPTIONS, INCLUDING THAT FOR "ANY STATE LAW THAT REGULATES INSURANCE," SHOULD BE GIVEN THE EXPANSIVE READING OF THE COURT OF APPEALS.

ERISA's savings clause exempts from ERISA preemption state laws that regulate insurance from a "common sense" point of view. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985); 29 U.S.C. § 1144(b)(2)(A). The Court then tests the result of the common sense inquiry by considering the three factors used to identify insurance law spared from federal preemption under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq*. *Moran*, 122 S. Ct. at 2159. These factors address (1) whether the law "has the effect of transferring or spreading a policyholder's risk," *Metropolitan Life*, 471 U.S. at 743 (citing *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)); (2) whether the law affects "an integral part of the policy relationship between the insurer and the insured," *id.*; and (3) whether the law "is limited to entities within the insurance industry," *id.*

A. The Kentucky AWP Statute Does Not Regulate The Business Of Insurance From A "Common Sense" Perspective.

To regulate insurance from a "common sense" perspective, it is insufficient for a state law to "have an impact on the insurance industry." *Pilot Life*, 481 U.S. at 50. Rather, a state law meets this requirement if it "is directed specifically at the insurance industry and is applicable only to insurance contracts." *UNUM*, 526 U.S. at 368. The Court has consistently recognized that the "business of insurance" is

not coextensive with the "business of *insurers*." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979), *cited in Moran*, 122 S. Ct. at 2159 (emphasis added).

The majority below failed to make this distinction. Instead, the majority focused on the fact that Kentucky's AWP statute applies to "insurers," *Kentucky Assoc. of Health Plans*, 227 F.3d at 361 – even though the statute's definition of "insurers" extends far beyond the "insurance industry" (*see infra* Part IV.B). The majority also relied on the expedient decision of the Kentucky legislature to codify its AWP statute within Kentucky's state insurance code. *Id.*

The majority's conclusion oversimplifies the "common-sense" inquiry because it fails even to examine what the AWP law regulates. As the dissent correctly pointed out, the Kentucky AWP law is "directed at the contracts between benefit plans and third parties, rather than being specifically directed at the insurance industry." 227 F.3d at 373 (citing *Pilot Life*, 481 U.S. at 50) (internal parenthetical omitted). Indeed, the statute's real focus is "regulating provider access to networks rather than specifically regulating the business of insurance." *Id.* at 375. Kentucky's AWP statute fails to satisfy the "common sense" test for regulating insurance.

B. The Kentucky AWP Statute Fails To Meet Any Of The McCarran-Ferguson Factors For Regulating The Business Of Insurance.

SHRM concurs with Petitioner's position that the AWP statute meets none of the McCarran-Ferguson

business of insurance factors, and comments only on the third – whether the law is limited to entities within the insurance industry.

Far from being "limited" to entities within the insurance industry, the statute attempts to reach virtually any entity involved in the delivery of health benefits. Indeed, the statute defines "insurer" to include "*any* . . . self-insurer . . . *not exempt from state regulation by ERISA*." KY. REV. STAT. § 304.17A-005(23) (emphasis added).

The language "not exempt from state regulation" shows an intent to regulate ERISA plans as much as possible, whether or not limited to the insurance industry. Any state law that purports to regulate insurance with language targeting self-insured plans, moreover, cannot possibly be said to be "limited" to the business of insurance.

The scope of Kentucky's AWP law thus lacks the limits of the state law recently considered in *Moran*. In *Moran*, the Court determined that Illinois' HMO Act, which provided HMO plan participants with a right to independent medical review of certain benefit denials, was saved from ERISA preemption because it regulated the business of insurance. 122 S. Ct. at 2156, 2163-64. Unlike the Kentucky statute, the Illinois Act was limited to HMOs, defined as "any organization . . . [which] provide[s] or arrange[s] for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers." *Id.* at 2157 (citing 215 Ill. Comp. Stat., ch. 125, § 1-2). This Court thus concluded that the Illinois

Act met the third McCarran-Ferguson factor. *Id.* at 2163, 2164. The same cannot be said about the Kentucky statute at issue.[5]

V. THERE IS NO GOOD REASON IN THIS CASE TO IGNORE THE CENTRAL POLICY OF ERISA AND NOT TO ERR ON THE SIDE OF PREEMPTION.

Congress has not yet reached any consensus on a fundamentally new national health care policy to replace ERISA's objective of encouraging employers to offer health benefits to employees on a voluntary basis. Since the passage of ERISA nearly 30 years ago, there have been many attempts to overhaul the federal health care system, including, *e.g.*, President Clinton's proposed Health Security Act (HSA), H.R. 3600, 103d Cong. (1993); S. 1757, 103d Cong. (1993), and the proposed Managed Competition Act of 1993 (MCA), H.R. 3222, 103d Cong. (1993), both of which provided for an employer-based system of health

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[5] The Illinois Act in *Moran* is also distinguishable from the Kentucky AWP statute because the Illinois Act regulated "an integral part of the policy relationship between the insurer and the insured." *Moran*, 122 S. Ct. at 2163 (quotation marks omitted). The Illinois Act provided "a legal right to the insured, enforceable against the HMO, to obtain an authoritative determination of the HMO's medical obligations." *Id.* at 2164. In contrast, the Kentucky Act regulates the relationship between the insurer and third parties (medical providers). The AWP statute "[does] not force the insurer to offer a benefit to insureds that was not available before the law. Rather, Kentucky's AWP laws merely force insurers to potentially make additional contractual arrangements with providers they might otherwise exclude." *Kentucky Assoc. of Health Plans*, 227 F.3d at 383 (Kennedy, J., dissenting).

coverage, but were not enacted. Congress also has considered and rejected, tabled or abandoned many broad-based proposals to amend ERISA to narrow the scope of its preemption provisions. *See, e.g.*, H.R. 2723, 106th Cong. (1999) (proposing to amend ERISA to allow lawsuits against health plans or insurers under state law); S. 6, 106th Cong. (1999) (same); H.R. 1415, 105th Cong. (1997) (proposing to amend ERISA's preemption provisions to allow state-law causes of action to recover damages for personal injury or wrongful death); S. 794, 102d Cong. (1991) (proposing to save from preemption state laws providing remedies against insurance companies who administer employee benefit plans).

When Congress *has* chosen to address health care, it has acted incrementally. *See, e.g.*, the continuation health coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), added to ERISA in 1986, 29 U.S.C. § 1161 *et seq.*; the portability and non-discrimination requirements of the Health Insurance Portability and Accountability Act (HIPAA), added to ERISA in 1996, 29 U.S.C. § 1181 *et seq.*; the minimum hospital stay requirement of the Newborns' and Mothers' Health Protection Act, added to ERISA in 1996, 29 U.S.C. § 1185; the requirements of the Mental Health Parity Act, added to ERISA in 1996, 29 U.S.C. § 1185a; and the requirements of coverage for reconstructive surgery following mastectomy as set forth in the Women's Health and Cancer Rights Act, added to ERISA in 1998, 29 U.S.C. § 1185b. Likewise, when Congress *has* chosen to allow state experimentation, it has acted specifically and incrementally. *See, e.g*, ERISA § 514(b)(6) (multi-employer welfare arrangements); (b)(7) (qualified domestic relations orders and qualified medical child support orders); (b)(8)

(states' rights to acquire COBRA rights of indigents); and (b)(9) (narrow exemption permitting states to establish more protective pre-existing condition rules in 29 U.S.C. § 1191). *See* 29 U.S.C. § 1144(b)(6) – (b)(9).

Overall policy for employer-sponsored health care emanates from ERISA, until Congress tells us otherwise. Until a new federal consensus is reached and enacted into law, it is not for the Court to abandon ERISA's policy favoring uniform employer freedom to control health costs without state intervention in their creative solutions, especially in the context of self-insured plans. Until a new federal consensus is reached and enacted into law, it would be a mistake to allow states like Kentucky to undermine the current and widespread reliance by ERISA plans on MCNs to deliver health care to American workers. As the Court of Appeals for the Eighth Circuit has recognized, "it is for Congress, not the courts, to reassess ERISA in light of modern insurance practices and the national debate over health care." *Prudential Ins. Co. of America v. National Park Med. Ctr.*, 154 F.3d 812, 830 (8th Cir. 1998) (citations omitted).

CONCLUSION

SHRM requests that the Court reverse the decision below, hold that Kentucky's AWP statute is preempted by ERISA, and preserve employers' ability to design health

plans to provide quality benefits at the least possible cost to American workers.

Respectfully submitted,

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